

**DEPARTMENT OF TRANSPORTATION****Federal Aviation Administration****14 CFR Parts 71**

[Docket FAA No. FAA-2013-0147; Airspace Docket No. 13-AWP-1]

**Establishment of Class E Airspace;  
Tuba City, AZ**

**AGENCY:** Federal Aviation Administration (FAA), DOT.

**ACTION:** Final rule; correction.

**SUMMARY:** This action corrects a final rule published in the **Federal Register** May 29, 2013 that establishes Class E en route airspace at the Tuba City VHF Omni-Directional Radio Range Tactical Air Navigational Aid (VORTAC), Tuba City, AZ. In that rule, an error was made in the legal description for Tuba City, identifying the region as ANM instead of AWP.

**DATES:** *Effective Date:* 0901 UTC, August 22, 2013. The Director of the Federal Register approves this incorporation by reference action under 1 CFR Part 51, subject to the annual revision of FAA Order 7400.9 and publication of conforming amendments.

**FOR FURTHER INFORMATION CONTACT:** Eldon Taylor, Federal Aviation Administration, Operations Support Group, Western Service Center, 1601 Lind Avenue SW., Renton, WA 98057; telephone (425) 203-4537.

**SUPPLEMENTARY INFORMATION:****History**

The FAA published a final rule in the **Federal Register** establishing Class E en route airspace at the Tuba City VORTAC, Tuba City, AZ (78 FR 32086, May 29, 2013). In the regulatory text, the region identifier ANM was incorrect, and is now corrected to AWP.

**Correction to Final Rule**

Accordingly, pursuant to the authority delegated to me, the legal description as published in the **Federal Register** on May 29, 2013 (78 FR 32086), Airspace Docket No. 13-AWP-1, FR Doc. 2013-12623, is corrected as follows:

**§ 71.1 [Amended]**

■ On page 32087, column 1, line 4, remove ANM AZ E6 Tuba City, AZ [NEW], and insert AWP AZ E6 Tuba City, AZ [Corrected].

Issued in Seattle, Washington, on July 29, 2013.

**Christopher Ramirez,**  
*Manager, Operations Support Group, Western Service Center.*

[FR Doc. 2013-18869 Filed 8-7-13; 8:45 am]

**BILLING CODE 4910-13-P**

**DEPARTMENT OF DEFENSE****Office of the Secretary****32 CFR Part 199**

[DOD-2010-HA-0072]

**RIN 0720-AB41**

**TRICARE; Reimbursement of Sole Community Hospitals and Adjustment to Reimbursement of Critical Access Hospitals**

**AGENCY:** Office of the Secretary, Department of Defense (DoD).

**ACTION:** Final rule.

**SUMMARY:** This Final Rule implements for Sole Community Hospitals (SCHs) the statutory provision at title 10, United States Code (U.S.C.), section 1079(j)(2) that TRICARE payment methods for institutional care be determined, to the extent practicable, in accordance with the same reimbursement rules as those that apply to payments to providers of services of the same type under Medicare. This Final Rule implements a reimbursement methodology similar to that applicable to Medicare beneficiaries for inpatient services provided by SCHs. It will be phased in over a several-year period. This Final Rule also provides for special reimbursement for labor/delivery and nursery services in SCHs and creates a possible General Temporary Military Contingency Payment Adjustment (GTMCPA) for inpatient services in SCHs and for Critical Access Hospitals (CAHs).

**DATES:** This rule is effective October 7, 2013.

*Applicability Date:* The regulations setting forth the revised reimbursement system shall be applicable for all admissions to Sole Community Hospitals and Critical Access Hospitals commencing on or after the first day of the month which is at least 120 days from the date of publication of this rule in the **Federal Register**.

**FOR FURTHER INFORMATION CONTACT:** Ann Fazzini, TRICARE Management Activity (TMA), Medical Benefits and Reimbursement Branch, telephone (303) 676-3803.

**SUPPLEMENTARY INFORMATION:****I. Executive Summary****A. Purpose of the Final Rule**

The purpose of this Final Rule is to implement for SCHs the statutory requirement that TRICARE inpatient care “payments shall be determined to the extent practicable in accordance with the same reimbursement rules as apply to payments to providers of services of the same type under Medicare.” Medicare pays SCHs the greater of the amount under the general inpatient prospective payment system method based on diagnosis-related groups (DRGs) or an amount based on the hospital’s reported costs. TRICARE pays for most hospital care under a DRG-based prospective payment system similar to Medicare’s, but exempted SCHs from this system, instead paying them billed charges. Paying billed charges is fiscally imprudent and inconsistent with TRICARE’s governing statute. Paying SCHs under a method similar to Medicare’s is prudent, practicable, and harmonious with the statute. The Final Rule will transition over a several year period from the current billed charge method to the new method. The transition will be gradual to reduce the impact on the SCHs. Network SCHs will have payment reductions limited to 10 percent per year. Non-network SCHs will have reductions limited to 15 percent per year.

The legal authority for this Final Rule is 10 U.S.C. 1079(j)(2).

**B. Summary of the Major Provisions of the Final Rule****1. Ultimate Payment Method for SCHs**

Following the transition period, TRICARE will reimburse SCHs for inpatient care the higher of the DRG-based amount applicable to most hospitals or an amount approximating the SCH’s costs. The cost-based amount will be determined by applying the SCH’s most recent Medicare cost-to-charge ratio (CCR) to the SCH’s charges. Individual claims will be paid under this cost-based method, followed by a year-end review to determine whether in the aggregate the DRG-based method would have paid more. If so, TRICARE will pay the SCH the aggregate difference.

**2. Transition Period**

To protect SCHs from sudden significant reductions, the Final Rule will gradually transition from the base year of paying 100 percent of allowable charges (which is either the billed charge or, in the case of network hospitals, a voluntary discounted

charge) to paying the percentage equal to the Medicare CCR (generally in the range of 30 to 50 percent). The transition rules prevent a reduction of more than 10 percentage points per year for network hospitals or 15 percentage points per year for non-network hospitals. So, for example, in the case of a non-network hospital with a CCR of 40 percent, payment in the first year would be 85 percent of the base year amount; 70 percent in the second year, 55 percent in the third year, and 40 percent in the fourth and subsequent years. In the case of a network hospital with a CCR of 40 percent that had agreed to a 5 percent discount (i.e., the allowable amount was 95 percent of billed charges) in the base year, payment in the first year would be 85 percent of the base year amount, 75 percent in the second year, 65 percent in the third year, 55 percent in the fourth year, 45 percent in the fifth year, and 40 percent in the sixth and subsequent years. During each year, the resulting aggregate payment amount would be compared to the aggregate amount that would have been provided under the DRG-based system, and if that would have been more, the difference will be paid.

### 3. Special Payment Rule for Labor/Delivery and Nursery Care

In response to public comments, the Final Rule includes a special payment rule for labor/delivery and nursery care in SCHs. Based on an assessment that the Medicare CCR does not accurately reflect the cost to charge ratio for these services, following the transition period, rather than applying the Medicare CCR to charges to labor/delivery and nursery DRGs, TRICARE will apply 130 percent of the Medicare CCR.

### 4. GTMCPA for SCHs and CAHs

One of the purposes of the TRICARE program is to support military members and their families during periods of war or contingency operations, when military facility capability may be diverted or insufficient to meet military readiness priorities. To preserve the availability of SCHs during such periods, the Final Rule includes authority for a year-end discretionary, temporary adjustment that the TMA Director may approve in extraordinary economic circumstances for a network hospital that serves a disproportionate share of Active Duty Service members (ADSMs) and Active Duty dependents (ADDs). This same adjustment possibility is also made available to Critical Access Hospitals since they share some attributes of SCHs.

TRICARE is in the process of developing policy and procedural

instructions for exercising the discretionary authority under the qualifying criteria for the GTMCPAs for inpatient services provided in SCHs and CAHs. The policy and procedural instructions will be available within 3 to 6 months following the applicability date of the new inpatient reimbursement methodology for SCHs. Hospitals will be able to request a GTMCPA approximately 14 months from the applicability date of the new reimbursement method as any GTMCPA will be based on twelve months of claims payment data under the new method. Once finalized, the policy and procedural instructions will be available in the TRICARE Reimbursement Manual at <http://manuals.tricare.osd.mil>. As with any discretionary authority exercised under the regulation, a determination approving or denying a GTMCPA for a hospital is not subject to the appeal and hearing procedures set forth in 32 CFR 199.10. Section 199.14(a)(8) of this final rule has been revised to clarify this point.

### C. Costs and Benefits

The economic impact of the Final Rule is to reduce DoD payments to SCHs, producing estimated DoD budgetary savings (cost avoidance) as follows:

FY 2013: \$36.5 million  
 FY 2014: \$80.2 million  
 FY 2015: \$130.3 million  
 FY 2016: \$186.1 million  
 FY 2017: \$243.1 million  
 Total FY 2013–2017: \$676.1 million

## II. Discussion of Final Rule

### A. Introduction and Background

In the **Federal Register** of July 5, 2011 (76 FR 39043), DoD published for public comment a Proposed Rule regarding an inpatient payment system for SCHs. Under 10 U.S.C. 1079(j)(2), the amount to be paid to hospitals, skilled nursing facilities, and other institutional providers under TRICARE, “shall be determined to the extent practicable in accordance with the same reimbursement rules as apply to payments to providers of services of the same type under Medicare.” Medicare reimburses SCHs for inpatient care the greatest of these aggregate amounts:

- (1) What the SCH would have been paid under the Medicare DRG method for all of that hospital’s Medicare discharges; or
- (2) The amount that would have been paid if the SCH were paid the average “cost” per discharge at that hospital in Fiscal Year (FY) 1982, 1987, 1996, or 2006 updated to the current year for all its Medicare discharges.

TRICARE currently pays SCHs for inpatient care in one of two ways:

(1) Network hospitals: Payment is an amount equal to billed charges less a negotiated discount. The discounted reimbursement is usually substantially greater than what would be paid using the DRG method, which TRICARE generally uses to reimburse hospitals for inpatient care; or

(2) Non-network hospitals: Payment is equal to billed charges.

TRICARE’s current method results in reimbursing SCHs substantially more than Medicare does for equivalent inpatient care. A change is needed to conform to the statute.

Under 32 Code of Federal Regulations (CFR) 199.14(a)(1)(ii)(D)(6), SCHs are currently exempt from the TRICARE DRG-based payment system. Based on the above statutory mandate, TRICARE is adopting in this Final Rule an approach that approximates the Centers for Medicare and Medicaid Services’ (CMS) method for SCHs.

### B. SCH Reimbursement Methodology

Establishing a TRICARE SCH inpatient reimbursement method exactly matching that of Medicare is not practicable. While TRICARE can calculate the aggregate DRG reimbursement for all TRICARE discharges by an SCH during a year, using the Medicare cost per discharge is not appropriate for TRICARE. Differences in the TRICARE and Medicare beneficiary case mix render the Medicare average cost per discharge not directly applicable for TRICARE purposes.

In addition, basing SCH reimbursement on annual updates to a TRICARE base-year average cost per discharge could result in inappropriate payments to some SCHs. At many SCHs, the number of TRICARE discharges per year is very low. Approximately half of the SCHs had fewer than 20 TRICARE discharges annually. The TRICARE average cost per discharge in one year may not be a good predictor of the average cost per discharge in a future year due to significant change in the case mix that can occur between two small sets of patients.

Alternatively, TRICARE could make payments equal to the SCH’s Medicare CCR multiplied by the hospital’s billed charges for inpatient services. For purposes of this rule, the Medicare CCR is the sum of Medicare’s operating and capital CCRs. This would avoid making payments unrelated to case mix and would be consistent with the Medicare principle of relating payments for SCHs to cost of services. This is the approach adopted in the Final Rule.

### C. TRICARE's SCH Phase-In Period

In introducing its current SCH reimbursement method, Medicare used a 3-year phase-in period to provide the hospitals time for making business and clinical process adjustments. TRICARE will have a phase-in period with a maximum 15 percent per-year reduction from the starting point for non-network hospitals and a 10 percent-per-year reduction for network hospitals. This involves calculating a hospital's ratio of allowed charges to billed charges for TRICARE discharges and reducing that by 15 percentage points each year for non-network hospitals and 10 percentage points each year for network hospitals until it reaches the hospital's Medicare CCR. For example, if a non-network hospital has a TRICARE-allowed to billed ratio of 100 percent, it would be paid 85 percent of billed charges in year 1, 70 percent in year 2, 55 percent in year 3, and 40 percent in year 4. For a network hospital that had a TRICARE-allowed to billed ratio of 98 percent, it would be paid 88 percent in year 1, 78 percent in year 2, 68 percent in year 3, and 58 percent in year 4. It should be noted that in no year could the TRICARE payment fall below costs, as measured by the Medicare CCR (most hospitals have costs equal to 30 to 50 percent of billed charges). This transition method would approximately follow the CHAMPUS Maximum Allowable Charge physician payment system reform precedent and limit reductions to no more than 15 percent per year during the phase-in period. It also provides an incentive for hospitals to remain in the network by allowing a 5 percentage point difference in payment reductions per year. Finally, it will buffer the revenue reductions experienced upon initial implementation of TRICARE's SCH payment reform while allowing hospitals sufficient time to adjust and budget for these reductions.

TRICARE will pay an SCH for inpatient services it provides during a year the greater of two aggregate amounts: (1) What the SCH would have been paid under the DRG method for all of that hospital's TRICARE discharges; or (2) an amount equal to the SCH's specific CCR multiplied by the hospital's billed charges for inpatient TRICARE services. This will be accomplished through a year-end adjustment to the reimbursements provided during the year.

### D. New SCHs and SCHs Without Inpatient Claims

TRICARE will pay a new SCH using the average Medicare CCR for all SCHs

calculated in the most recent year until its Medicare CCR is available in the CMS Inpatient Provider Specific File (PSF). For SCHs that had no inpatient claims from TRICARE prior to implementation of the SCH payment reform but do have a claim, TRICARE will pay them based directly on their Medicare CCR.

### E. SCH GTMCPA

In addition to the SCH phase-in period outlined above, a GTMCPA for inpatient services will be available for TRICARE network hospitals deemed essential for military readiness and support during contingency operations. The TMA Director, or designee, may approve an SCH GTMCPA for hospitals that serve a disproportionate share of ADSMs and ADDs. Specific procedures for requesting an SCH GTMCPA will be outlined in the TRICARE Reimbursement Manual.

### F. Essential Access Community Hospitals (EACH)

The SCH reform encompasses all SCHs as defined by Medicare that have inpatient stays for TRICARE patients. It also include hospitals classified by CMS as EACHs because for payment purposes, CMS treats as an SCH any hospital that CMS designates as an EACH. In other words, EACHs are subject to the SCH reform in this final rule. There are two EACHs in existence: Via Christi Hospital in Pittsburg, Kansas; and Avera Queen of Peace Hospital in Mitchell SD. Both have submitted claims to TRICARE.

### G. CAH GTMCPA

On August 31, 2009, we published in the **Federal Register** a Final Rule (74 FR 44752), which implemented a reimbursement methodology similar to that furnished to Medicare beneficiaries for services provided by CAHs (i.e., reimbursing them 101 percent of reasonable costs). It was brought to our attention that there may be some CAHs that are deemed essential for military readiness and support during contingency operations. Consequently, the Proposed Rule published in the **Federal Register** of July 5, 2011 (76 FR 39043), also proposed a CAH GTMCPA for TRICARE network hospitals deemed essential for military readiness and contingency operations. The TMA Director, or designee, may approve a CAH GTMCPA for hospitals that serve a disproportionate share of ADSMs and ADDs. Specific procedures for requesting a CAH GTMCPA will be outlined in the TRICARE Reimbursement Manual.

### III. Public Comments

The TRICARE SCH Proposed Rule (76 FR 39043) published on July 5, 2011, provided a 60-day public comment period. Following is a summary of the public comments and our responses.

*Comment:* Several commenters stated that using the Medicare CCR is not appropriate because of differences in the type of services utilized by the TRICARE beneficiary population, as compared to the Medicare population, especially services related to labor/delivery and newborn care. These commenters stated that use of the Medicare CCR is not directly applicable for TRICARE purposes and they recommended DoD use an adjusted Medicare CCR equal to the Medicare CCR multiplied by a factor of 1.464 to more accurately account for TRICARE costs.

*Response:* Under the proposed transition period outlined in the Proposed Rule and adopted in this Final Rule, it will take an average of 4 to 6 years for most network SCHs to reach their Medicare CCR reimbursement level. In response to these comments, we have considered whether we should modify our proposed approach of using the Medicare CCR for all services. We analyzed data from SCH cost centers utilized by TRICARE beneficiaries, including labor/delivery and nursery to calculate a CCR for TRICARE patients, referred to as the TRICARE-specific CCR. We found that the TRICARE-specific CCR was similar to the Medicare CCR at most SCHs. However, we also found that, in addition to TRICARE patients obviously using more maternity services than Medicare beneficiaries, the labor/delivery and nursery cost centers have higher CCRs than other cost centers. We found, on average, that the TRICARE-specific CCR for nursery and labor/delivery services was 30 percent higher than the Medicare CCR. As a result, this Final Rule includes an adjustment for inpatient nursery and labor/delivery services. This adjustment will start at the end of the transition period when each SCH reaches its Medicare CCR (approximately 4 to 6 years from implementation of this Final Rule). The adjustment will be 130 percent of the Medicare CCR, rather than the Medicare CCR, for care that groups to labor/delivery and nursery DRGs.

*Comment:* These same commenters recommended DoD modify its approach so that TRICARE payments will be equal to the highest of the SCH's CCRs from four base years (1982, 1987, 1996, and 2006) multiplied by the hospital's billed charge for services. They further state

the CCR should be adjusted to reflect TRICARE costs, as described in the above comment.

*Response:* Medicare does not use CCRs from these earlier years to pay SCHs. Instead, Medicare uses the cost per discharge from those years. Thus, using the highest CCR from these earlier years is not consistent with Medicare's approach. The approach proposed in this rule uses the most recent CCR data for a specific hospital which is the best reflection of a hospital's current costs relative to its billed charges, not the costs from 10–30 years ago.

*Comment:* One commenter requested that TRICARE clarify that SCHs will need to file requests for capital cost reimbursement.

*Response:* TRICARE's payment for SCHs will be based on a CCR which is equal to the sum of the Medicare operating CCR and the Medicare capital CCR. Thus, TRICARE SCH reimbursement will include capital costs and SCHs will not need to request additional reimbursement for capital.

*Comment:* One commenter proposed that TRICARE pay SCHs using the average Medicare cost per discharge (the highest cost per discharge from several specified base year cost reports) inflated forward using the same factor used to update TRICARE DRG payments. Due to differences between the TRICARE and Medicare case mixes, the commenter suggested that the Medicare cost per discharge value be adjusted by the ratio of the TRICARE standardized payment amount (the Adjusted Standardized Amount in the TRICARE Inpatient Prospective Payment System) to the Medicare standardized payment amount.

*Response:* The TRICARE and Medicare Inpatient Prospective Payment Systems use different weights and the allowed amounts per discharge are quite different due to differences in the weights and case mix. Thus, this proposed method would not be appropriate.

*Comment:* Two commenters recommended DoD limit its per-year reductions in payments to 5 percent for all SCHs rather than the 10 and 15 percent proposed. Another commenter requested the per-year reductions in payments be limited to 5 percent for network and 10 percent for non-network SCHs.

*Response:* Currently, SCHs receive TRICARE reimbursement for the most common services at more than twice the level of other acute hospitals. Under the transition period outlined in the Proposed Rule and adopted in the Final Rule, it will take an average of 4 to 6 years for most network SCHs to reach

their Medicare CCR reimbursement levels. A reduction in payment of 10 percent for network SCHs and 15 percent for non-network SCHs buffers the decrease in revenues that hospitals will be experiencing during implementation of the TRICARE SCH reimbursement methodology. The transition period will allow SCHs sufficient time to adjust and budget for these reductions. The proposed payment reductions provide an incentive for hospitals to remain in the network by allowing a 5 percent difference in payment reductions per year. Additionally, reducing the payment by 5 percent per year during the transition would increase the time it will take to comply with the statute that governs TRICARE. A 10 to 15 percent reduction in payment during the transition is reasonable.

*Comment:* Several commenters recommended DoD incorporate into TRICARE reimbursement methodology the additional payment protections that Medicare affords SCHs, and asked that other general Medicare payment adjustments be incorporated, including the low-volume adjustment, geographic wage index reclassification, and disproportionate share hospital (DSH) payments.

*Response:* When TRICARE calculates DRG payments, Medicare's geographic wage index classification will be used. With respect to DSH payments, when DoD implemented the TRICARE DRG system in 1987, the supplementary information in the Final Rule stated that we would not implement the DSH adjustment. DoD decided not to implement the DSH adjustment because the TRICARE DRG system would pay hospitals adequately for TRICARE patients. This is also true for the SCH payment methodology adopted in this Final Rule. By creating an adjustment for labor/delivery and nursery services as well as a possible GTMCPA for hospitals that serve a disproportionate share of ADSMs and ADDs, hospitals are adequately compensated for care received by TRICARE beneficiaries. We believe that these specific adjustments designed to address the needs of the TRICARE beneficiaries negates the need for any additional adjustments.

*Comment:* Several commenters recommended TRICARE develop an Medicare Dependent Hospital (MDH) payment methodology comparable to the SCH methodology because Medicare payments to MDHs track the methodology used to reimburse SCHs. Two of these commenters also recommended TRICARE recognize the MDH classification and adopt special payment provisions for MDHs.

*Response:* Medicare identifies rural hospitals with less than 100 beds which have 60 percent or more of their admissions or inpatient days reimbursed by Medicare as MDHs. Under Medicare rules, a hospital cannot be both an SCH and an MDH. Under current TRICARE rules, MDHs are paid under the normal DRG payment method. The Proposed Rule for TRICARE reimbursement of SCHs did not propose a special payment method for MDHs. It is notable that having a high percentage of Medicare admissions or days does not mean the hospital has a high percentage of TRICARE admissions or days. Further, this SCH rule does not change the status-quo for TRICARE payments to MDH hospitals. Outside the scope of this rule making, TRICARE will analyze whether it is practicable and appropriate to make any changes in reimbursements to hospitals classified by Medicare as MDHs based on Medicare's payment methodology for MDHs.

*Comment:* One commenter requested that the rules for reimbursement remain unchanged.

*Response:* The statutory provision at 10 U.S.C. 1079(j)(2) mandates that TRICARE payment methods for institutional care be determined, to the extent practicable, in accordance with the same reimbursement rules as those that apply to payments to providers of services of the same type under Medicare. Based on this statutory requirement, TRICARE is adopting a method similar to Medicare's payment system for reimbursement of SCH inpatient services.

*Comment:* Several commenters are concerned the proposed payment methodology will result in significant cuts and compromise access to care.

*Response:* TRICARE will make payments equal to the SCH's specific Medicare CCR multiplied by the hospital's billed charges for inpatient services. This is consistent with the Medicare principle of relating payments for SCHs to cost of services. Following the transition, SCHs with patients in delivery and newborn DRGs will receive payments for these patients based on the level of billed charges multiplied by a factor equal to 130 percent of the Medicare CCR. Those SCHs with a high proportion of ADSMs/ADDs admissions may be eligible to receive a GTMCPA. Additionally, the phase-in period will buffer the revenue reductions and will allow hospitals sufficient time to adjust and budget for this revised reimbursement methodology. Hospitals can also become network providers, for which the percentage per-year reduction of 10 percent is a more gradual step-

down than the percentage per-year reduction of 15 percent for non-network hospitals. We believe these feature are quite adequate to assure reasonable reimbursement and protect access to care.

*Comment:* One commenter states that TRICARE's higher inpatient payments off-set losses on outpatient services provided to TRICARE.

*Response:* The statutory provision at 10 U.S.C. 1079(j)(2) mandates that TRICARE payment methods for institutional care be determined, to the extent practicable, in accordance with the same reimbursement rules as those that apply to payments to providers of services of the same type under Medicare. Based on this statutory requirement, TRICARE is adopting Medicare's payment system for reimbursement of SCH inpatient services. In addition, TRICARE payments for hospital outpatient services are fully adequate.

*Comment:* The above commenter further states the proposed cuts will likely result in a reduction in service line offerings.

*Response:* We value the services offered by all hospitals and providers who treat TRICARE beneficiaries, including ADSMs, ADDs, Retirees, and our Wounded Warriors. The transition schedule in this Final Rule will reduce the effects of the transition going from a billed-charge reimbursement system to payments aligned with Medicare reimbursement levels. These provisions include a multi-year transition period and the possibility of a GTMCPA. Thus, we believe the final rule not only complies with our statutory mandate, but does so in a fair and reasonable manner to SCHs.

#### IV. Regulatory Impact Analysis

##### A. Overall Impact

DoD has examined the impacts of this Final Rule as required by Executive Orders (E.O.s) 12866 (September 1993, Regulatory Planning and Review) and 13563 (January 18, 2011, Improving Regulation and Regulatory Review), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96–354), the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4), and the Congressional Review Act (5 U.S.C. 804(2)).

1. Executive Order 12866 and Executive Order 13563

E.O.s 12866 and 13563 direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize

net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). E.O. 13563 emphasizes the importance of quantifying both costs and benefits, reducing costs, harmonizing rules, and promoting flexibility. A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects (\$100 million or more in any one year).

We estimate that the effects of the SCH provisions that would be implemented by this rule would result in SCH revenue reductions exceeding \$100 million in at least one year. We estimate the reduction in hospital revenues under the SCH reform for its first full year of implementation compared to expenditures in that same period without the proposed SCH changes, to be well below the \$100 million level because of the transition features of the Final Rule. However, after several years in the transition period, the amount of revenue reductions will reach the \$100 million per year threshold.

We estimate that this rulemaking is “economically significant” as measured by the \$100 million threshold and, hence, also a major rule under the Congressional Review Act. Accordingly, we have prepared a regulatory impact analysis that, to the best of our ability, presents the costs and benefits of the rulemaking.

2. Congressional Review Act. 5 U.S.C. 801

Under the Congressional Review Act, a major rule may not take effect until at least 60 days after submission to Congress of a report regarding the rule. A major rule is one that would have an annual effect on the economy of \$100 million or more or have certain other impacts. This Final Rule is a major rule under the Congressional Review Act.

3. Regulatory Flexibility Act (RFA)

The RFA requires agencies to analyze options for regulatory relief of small businesses if a rule has a significant impact on a substantial number of small entities. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and small governmental jurisdictions. Most hospitals are considered to be small entities, either by being nonprofit organizations or by meeting the Small Business Administration (SBA) definition of a small business (having revenues of \$34.5 million or less in any one year). For purposes of the RFA, we have determined that all SCHs would be considered small entities according to the SBA size standards. Individuals and

States are not included in the definition of a small entity. Therefore, this Final Rule would have a significant impact on a substantial number of small entities. The Regulatory Impact Analysis, as well as the contents contained in the preamble, also serves as the Final Regulatory Flexibility Analysis.

##### 4. Unfunded Mandates

Section 202 of the Unfunded Mandates Reform Act of 1995 also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any one year of \$100 million in 1995 dollars, updated annually for inflation. That threshold level is currently approximately \$140 million. This Final Rule will not mandate any requirements for State, local, or tribal governments or the private sector.

##### 5. Paperwork Reduction Act

This rule will not impose significant additional information collection requirements on the public under the Paperwork Reduction Act of 1995 (44 U.S.C. 3502–3511). Existing information collection requirements of the TRICARE and Medicare programs will be utilized. We do not anticipate any increased costs to hospitals because of paperwork, billing, or software requirements since we are keeping TRICARE's billing/coding requirements (i.e., hospitals will be coding and filing claims in the same manner as they currently are with TRICARE).

##### 6. Executive Order 13132, “Federalism”

This rule has been examined for its impact under E.O. 13132, and it does not contain policies that have federalism implications that would have substantial direct effects on the States, on the relationship between the national Government and the States, or on the distribution of power and responsibilities among the various levels of Government. Therefore, consultation with State and local officials is not required.

##### B. Hospitals Included In and Excluded From the SCH Reforms

1. The SCH reform encompasses all SCHs as defined by Medicare that have inpatient stays for TRICARE patients. It also includes hospitals classified by CMS as Essential Access Community Hospitals (EACH) because for payment purposes, CMS treats as an SCH any hospital that CMS designates as an EACH. In other words, EACHs are subject to the SCH reform in this final rule. There are two EACHs in existence: Via Christi Hospital in Pittsburg, Kansas; and Avera Queen of Peace

Hospital in Mitchell SD. Both have submitted claims to TRICARE. Over a six month period, Via Christi hospital submitted about \$309,000 in TRICARE inpatient claims and Avera Queen of Peach submitted about \$270,000 in TRICARE inpatient claims.

2. Hospitals that are paid by Medicare and TRICARE under a cost containment waiver are not included in the SCH Reform.

### *C. Analysis of the Impact of Policy Changes on Payment Under SCH Reform Alternatives Considered*

Alternatives that we considered, the proposed changes that we will make, and the reasons that we have chosen each option are discussed below.

#### *1. Alternatives Considered for Addressing Reduction in SCH Payments*

Analysis of the effects of paying SCHs using the computation of either the greater of what the SCH would have been paid under the DRG method for all of that hospital's TRICARE discharges or an amount equal to the SCH's specific CCR multiplied by the hospital's billed charges for the TRICARE services approach would reduce the TRICARE payments to these SCHs by an average of over 50 percent. This approach would pay each SCH the greater of two aggregate amounts: (1) The sum of the TRICARE-allowed amounts if all the TRICARE inpatient admissions over a 12-month period were paid using the TRICARE DRG method; or (2) the TRICARE-allowed amounts if all the TRICARE inpatient admissions over a 12-month period were paid using the CCR approach (in which the TRICARE-allowed amount for each admission is equal to the billed charge for that admission multiplied by the hospital's historical CCR). Table 3 provides our estimate of the impact of this approach without any transitions.

Because the impact of moving from a charge-based reimbursement to a cost-based reimbursement similar to Medicare's would produce large reductions in the TRICARE-allowed amounts for all types of SCHs, we considered a phase-in of this approach over a 4-year period. Under this option, the CCR portion of the approach would be modified so that the hospital's billed charge on each claim would not be multiplied by the hospital's CCR until the fourth year (when the transition was complete). In the first 3 years, the billed charges for each claim would be multiplied by a ratio so that there was an equal reduction in the ratio used each year over the 4-year transition. For example, if the hospital were receiving

100 percent of its billed charges prior to implementation of the SCH reform and it had a CCR of 0.32, then its billed charges would be multiplied by factors of 0.83, 0.66, and 0.49 in the first 3 years respectively so that each year the payment ratio declined by an equal amount (in this case by a factor of 0.17). In each year, the aggregate level of allowed amounts produced using the CCR approach at each SCH would be compared with the aggregate level of DRG-allowed amounts at the SCH, and the SCH would be paid the greater of the two aggregate amounts. This 4-year transition would allow hospitals to have a phased transition to the cost-based rates. Although this option would provide a multi-year period for SCHs to transition to the cost-based rates, we did not choose this option because it would still result in large reductions for some SCHs over a relatively short period.

A second option we considered was to have a transition based on a reduction of 15 percentage points per year in the allowed amounts for each SCH. Under this option, the CCR portion in this approach would be modified. During the transition period, the billed charges on each claim at an SCH would be multiplied by a factor so that the ratio decreased by 15 percentage points each year from the level in the previous year. For example, if the SCH were receiving 100 percent of its billed charges prior to SCH reform and it had a CCR of 0.32, then its billed charges would be multiplied by factors of 0.85, 0.70, 0.55, and 0.40 in the first 4 years respectively, so that each year the ratio declined by 15 percentage points. In the fifth year, the ratio would be set at 0.32, the hospital's CCR. (The actual number of years of transition will depend on the hospital's CCR and could be more or less than the 4 years in this example as the ratio will never be less than the CCR.) In each year, the aggregate level of allowed amounts produced using the CCR approach at each SCH would be compared with the aggregate level of DRG-allowed amounts at the SCH and the SCH would be paid the greater of the two aggregate amounts. This type of transition ensures that there is a manageable reduction in the level of payments each year for each hospital. We selected this option for SCHs not in the TRICARE network.

#### *2. Alternatives Considered for SCHs in the TRICARE Network*

We were concerned there might be access problems at some hospitals with a high concentration of TRICARE patients if their payments were decreased significantly. In particular,

we were concerned that some hospitals might leave the TRICARE network if payments were reduced too quickly. This was a particular concern because 24 of the 25 SCHs with the highest levels of TRICARE-allowed amounts in the first 6 months of Calendar Year 2010 were in the TRICARE network. Thus, the SCHs that would face the largest reductions in the level of TRICARE-allowed amounts from TRICARE's SCH reform would be network hospitals.

An option we considered, and the one we adopt in this rule, is to provide a 10 percent-per-year reduction in the allowed amounts for SCHs in the TRICARE network. This option would modify the CCR portion of the approach using the most recent adjudicated Medicare cost report. During the transition period, the billed charges on each claim at an SCH in the TRICARE network would be multiplied by a factor so that the ratio decreased by 10 percentage points each year from a FY 2012 base year (in contrast to 15 percentage points for non-network hospitals). For example, if a TRICARE network SCH had allowed amounts equal to 92 percent of its billed charges prior to SCH reform, and it had a CCR of 0.35, then its billed charges would be multiplied by factors of 0.82, 0.72, 0.62, 0.52, and 0.42 in the first 5 years, respectively, to calculate the allowed amounts. Under this approach, each year the ratio for network SCHs would decline by ten percentage points. In the sixth year, the ratio would be set at 0.35, the hospital's CCR (assuming that the hospital's CCR had remained at 0.35). In each year, the aggregate level of allowed amounts produced using the CCR approach at each SCH would be compared with the aggregate level of DRG-allowed amounts at the SCH, and the SCH would be paid the greater of the two aggregate amounts. This type of transition ensures that there is a manageable reduction in the level of payments each year for each hospital. We selected this option for SCHs in the TRICARE network. The impact assessment of implementation of SCH during the first year appears in Table 1. The estimates of reduction are based on TRICARE claims data.

#### *D. Effects on SCHs*

Table 1 shows the impact of revised SCH inpatient reimbursement during FY 2013. Table 2 shows projected TRICARE reduction in reimbursement for the top 20 SCHs. Table 3 shows the full amount of the reduction without phase-in and transitional payments.

TABLE 1—ESTIMATED IMPACT OF SCH REFORMS ON TRICARE-ALLOWED AMOUNTS AT SOLE COMMUNITY HOSPITALS DURING THE FY 2013 FIRST YEAR OF PHASE-IN (WITH TRANSITION PAYMENTS)

[Excludes any General Temporary Military Contingency Payment Adjustments]

Estimated allowed under current policy (\$M)	Allowed amounts under SCH reform (\$M)	Reduction in allowed amounts (\$M)	SCH reform allowed as percent of current policy allowed
\$365	\$328	\$37	90

TABLE 2—IMPACT OF FIRST YEAR FOR TOP 20 SOLE COMMUNITY HOSPITALS

[Excludes any General Temporary Military Contingency Payment Adjustments]

Hospital	City	State	Reduction in FY 2013 (\$M)
Onslow Memorial Hospital	Jacksonville	FL	2.0
Rapid City Regional Hospital	Rapid City	SD	1.6
Cheyenne Regional Medical Center	Cheyenne	WY	1.6
Sierra Vista Regional Health Center	Sierra Vista	AZ	1.5
Beaufort County Memorial Hospital	Beaufort	SC	1.8
Carolina East Health System	New Bern	NC	1.6
Benefis Health System	Great Falls	MT	1.4
Yuma Regional Medical Center	Yuma	AZ	1.6
Trinity Medical Center	Minot	ND	1.1
Gerald Champion Hospital	Alamogordo	NM	0.7
Phelps County Regional Medical Center	Rolla	MO	0.7
Altru Hospital	Grand Forks	ND	0.7
Wayne Memorial Hospital	Goldsboro	NC	0.7
Samaritan Medical Center	Watertown	NY	1.5
Western Missouri Medical Center	Warrensburg	MO	0.6
Fairbanks Memorial Hospital	Fairbanks	AK	0.6
Lower Keys Medical Center	Key West	FL	0.6
Matsu Regional Hospital	Palmer	AK	0.5
Camden Medical Center	St. Marys	GA	0.5
Flagstaff Medical Center	Flagstaff	AZ	0.7

TABLE 3—ESTIMATED HYPOTHETICAL FY 2013 IMPACT OF COST-BASED REIMBURSEMENT ON TRICARE-ALLOWED AMOUNTS AT SOLE COMMUNITY HOSPITALS WITHOUT TRANSITION PAYMENTS

[Excludes any General Temporary Military Contingency Payment Adjustments]

Current policy (\$M)	Cost-based reimbursement (\$M)	Reduction in TRICARE-allowed amounts (\$M)	Allowed amount under cost-based reimbursement as percent of current policy allowed
\$365	\$157	\$208	43

**List of Subjects in 32 CFR Part 199**

Claims, Dental health, Health care, Health insurance, Individuals with disabilities, Military personnel.

Accordingly, 32 CFR Part 199 is amended as follows:

**PART 199—[AMENDED]**

■ 1. The authority citation for part 199 continues to read as follows:

**Authority:** 5 U.S.C. 301; 10 U.S.C. Chapter 55.

■ 2. Paragraph 199.2(b) is amended by adding definitions for “Essential Access Community Hospital (EACH)” and “Sole community hospital (SCH)” in alphabetical order to read as follows:

**§ 199.2 Definitions.**

\* \* \* \* \*

(b) \* \* \*

*Essential Access Community Hospital (EACH).* A hospital that is designated by the Centers for Medicare and Medicaid Services (CMS) as an EACH and meets the applicable requirements established by § 199.14(a)(7)(vi).

\* \* \* \* \*

*Sole community hospital (SCH).* A hospital that is designated by CMS as an SCH and meets the applicable requirements established by § 199.6(b)(4)(xvii).

\* \* \* \* \*

■ 3. Section 199.6 is amended by adding new paragraph (b)(4)(xvii) to read as follows:

**§ 199.6 TRICARE—authorized providers.**

\* \* \* \* \*

(b) \* \* \*

(4) \* \* \*

(xvii) *Sole community hospitals (SCHs).* SCHs must meet all the criteria for classification as an SCH under 42 CFR 412.92, in order to be considered an SCH under the TRICARE program.

\* \* \* \* \*

■ 4. Section 199.14 is amended by:

a. Revising paragraph (a)(1)(ii)(D)(6), paragraph (a)(2)(viii)(D), paragraph (a)(3), the first sentence of paragraph (a)(4), and the introductory text of paragraph (a)(6); and

b. Adding new paragraphs (a)(7) and (8).

The revisions and additions read as follows:



**§ 199.14 Provider reimbursement methods.**

- (a) \* \* \*  
 (1) \* \* \*  
 (ii) \* \* \*  
 (D) \* \* \*

**(6) Sole community hospitals (SCHs).**

Prior to implementation of the SCH reimbursement method described in paragraph (a)(7) of this section, any hospital that has qualified for special treatment under the Medicare prospective payment system as an SCH (see subpart G of 42 CFR part 412) and has not given up that classification is exempt from the CHAMPUS DRG-based payment system.

\* \* \* \* \*

- (2) \* \* \*  
 (viii) \* \* \*

**(D) Sole community hospitals (SCHs).**

Prior to implementation of the SCH reimbursement method described in paragraph (a)(7) of this section, any hospital that has qualified for special treatment under the Medicare prospective payment system as an SCH and has not given up that classification is exempt.

\* \* \* \* \*

(3) *Reimbursement for inpatient services provided by a CAH.* (i) For admissions on or after December 1, 2009, inpatient services provided by a CAH, other than services provided in psychiatric and rehabilitation distinct part units, shall be reimbursed at allowable cost (i.e., 101 percent of reasonable cost) under procedures, guidelines and instructions issued by the TMA Director, or designee. This does not include any costs of physician services or other professional services provided to CAH inpatients. Inpatient services provided in psychiatric distinct part units would be subject to the CHAMPUS mental health payment system. Inpatient services provided in rehabilitation distinct part units would be subject to billed charges.

(ii) The percentage amount stated in paragraph (a)(3)(i) of this section is subject to possible upward adjustment based on a inpatient GTMCPA for TRICARE network hospitals deemed essential for military readiness and support during contingency operations under paragraph (a)(8) of this section.

(4) *Billed charges and set rates.* The allowable costs for authorized care in all hospitals not subject to the CHAMPUS DRG-based payment system, the CHAMPUS mental health per-diem system, the reasonable cost method for CAHs, or the reimbursement rules for SCHs shall be determined on the basis of billed charges or set rates. \* \* \*

\* \* \* \* \*

(6) *Hospital outpatient services.* This paragraph (a)(6) identifies and clarifies payment methods for certain outpatient services, including emergency services, provided by hospitals.

\* \* \* \* \*

(7) *Reimbursement for inpatient services provided by an SCH.* (i) In accordance with 10 U.S.C. 1079(j)(2), TRICARE payment methods for institutional care shall be determined, to the extent practicable, in accordance with the same reimbursement rules as those that apply to payments to providers of services of the same type under Medicare. TRICARE's SCH reimbursements approximate Medicare's for SCHs. Inpatient services provided by an SCH, other than services provided in psychiatric and rehabilitation distinct part units, shall be reimbursed through a two-step process.

(ii) The first step referred to in paragraph (a)(7)(i) of this section will be to calculate the TRICARE allowable cost by multiplying the applicable TRICARE percentage by the billed charge amount on each institutional inpatient claim. The applicable TRICARE percentage is the greater of: the SCH's most recently available cost-to-charge ratio (CCR) from the Centers for Medicare and Medicaid Services' (CMS') inpatient Provider Specific File (after the ratio has been converted to a percentage), or the TRICARE allowed-to-billed ratio, defined as the ratio of the TRICARE allowed amounts (including discounts) to the amount of billed charges for TRICARE inpatient admissions at the SCH in FY 2012 (after it has been converted to a percentage). The TRICARE allowed-to-billed ratio in FY 2012 shall be reduced as follows (after the ratio has been converted to a percentage):

(A) In the first year of implementation, 10 percentage points for network SCHs and 15 percentage points for non-network SCHs.

(B) In the second year of implementation, 20 percentage points for network SCHs and 30 percentage points for non-network SCHs.

(C) In the third year of implementation, 30 percentage points for network SCHs and 45 percentage points for non-network SCHs.

(D) In the fourth year of implementation, 40 percentage points for network SCHs and 60 percentage points for non-network SCHs.

(E) In the fifth year of implementation, 50 percentage points for network SCHs and 75 percentage points for non-network SCHs.

(F) In the sixth year of implementation, 60 percentage points

for network SCHs and 90 percentage points for non-network SCHs.

(G) In the seventh year of implementation, 70 percentage points for network SCHs and 100 percentage points for non-network SCHs.

(H) In the eighth year of implementation, 80 percentage points for network SCHs and 100 percentage points for non-network SCHs.

(I) In the ninth year of implementation, 90 percentage points for network SCHs and 100 percentage points for non-network SCHs.

(J) In the tenth year of implementation, 100 percentage points for network SCHs and 100 percentage points for non-network SCHs.

(iii) The second step referred to in paragraph (a)(7)(i) of this section is a year-end adjustment. The year-end adjustment will compare the aggregate allowable costs over a 12-month period under paragraph (a)(7)(ii) of this section to the aggregate amount that would have been allowed for the same care using the TRICARE DRG-method (under paragraph (a)(1) of this section). In the event that the DRG method amount is the greater, the year-end adjustment will be the amount by which it exceeds the aggregate allowable costs. In addition, the year-end adjustment also may incorporate a possible upward adjustment for inpatient services based on a GTMCPA for TRICARE network hospitals under paragraph (a)(8) of this section.

(iv) At the end of an SCH's transition period, when the SCH reaches its Medicare CCR, a special allowable cost shall be applicable for discharges that group to inpatient nursery and labor/delivery DRGs. For these discharges, instead of using the percentage of the SCH's Medicare cost-to-charge ratio (as described in paragraph (a)(7)(ii) of this section), the percentage will be 130 percent of the Medicare CCR.

(v) The SCH reimbursement provisions of paragraphs (a)(7)(i) through (iv) of this section do not apply to any costs of physician services or other professional services provided to SCH inpatients (which are subject to individual provider payment provisions of this section), inpatient services provided in psychiatric distinct part units (which are subject to the CHAMPUS mental health per-diem payment system), or inpatient services provided in rehabilitation distinct part units (which are reimbursed on the basis of billed charges or set rates).

(vi) The SCH payment system under this paragraph (a)(7) applies to hospitals classified by CMS as Essential Access Community Hospitals (EACHs).



(vii) The SCH payment system under this paragraph (a)(7) does not apply to hospitals in States that are paid by Medicare and TRICARE under a cost containment waiver.

(8) *General temporary military contingency payment adjustment for SCHs and CAHs.* (i) Payments under paragraph (a) of this section for inpatient services provided by SCHs and CAHs may be supplemented by a GTMCPA. This is a year-end discretionary, temporary adjustment that the TMA Director may approve based on all the following criteria:

(A) The hospital serves a disproportionate share of ADSMs and ADDs;

(B) The hospital is a TRICARE network hospital;

(C) The hospital's actual costs for inpatient services exceed TRICARE payments or other extraordinary economic circumstance exists; and,

(D) Without the GTMCPA, DoD's ability to meet military contingency mission requirements will be significantly compromised.

(ii) Policy and procedural instructions implementing the GTMCPA will be issued as deemed appropriate by the Director, TMA, or a designee. As with other discretionary authority under this Part, a decision to allow or deny a GTMCPA to a hospital is not subject to the appeal and hearing procedures of § 199.10.

\* \* \* \* \*

Dated: July 29, 2013.

**Patricia L. Toppings,**  
*OSD Federal Register Liaison Officer,*  
*Department of Defense.*

[FR Doc. 2013-19154 Filed 8-7-13; 8:45 am]

BILLING CODE 5001-06-P

## DEPARTMENT OF HOMELAND SECURITY

### Coast Guard

#### 33 CFR Part 100

[Docket No. USCG-2013-0327]

RIN 1625-AA08

### Special Local Regulations; Regattas and Marine Parades in the Captain of the Port Lake Michigan Zone

**AGENCY:** Coast Guard, DHS.

**ACTION:** Final rule.

**SUMMARY:** The Coast Guard is amending special local regulations for annual regattas and marine parades in the Captain of the Port Lake Michigan Zone. This rule is intended to provide for the

safety of life and property on navigable waters immediately prior to, during, and immediately after regattas or marine parades. This rule will establish restrictions upon, and control the movement of, vessels in a portion of the Captain of the Port Lake Michigan Zone.

**DATES:** This final rule is effective September 9, 2013.

**ADDRESSES:** Documents mentioned in this preamble are part of docket USCG-2013-0327. To view documents mentioned in this preamble as being available in the docket, go to <http://www.regulations.gov>, type the docket number in the "SEARCH" box and click "SEARCH." Click on Open Docket Folder on the line associated with this rulemaking. You may also visit the Docket Management Facility in Room W12-140 on the ground floor of the Department of Transportation West Building, 1200 New Jersey Avenue SE., Washington, DC 20590, between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays.

**FOR FURTHER INFORMATION CONTACT:** If you have questions on this rule, contact MST1 Joseph McCollum, Prevention Department, Coast Guard Sector Lake Michigan, Milwaukee, WI at (414) 747-7148 or by email at [Joseph.P.McCollum@USCG.mil](mailto:Joseph.P.McCollum@USCG.mil). If you have questions on viewing or submitting material to the docket, call Barbara Hairston, Program Manager, Docket Operations, telephone 202-366-9826.

#### SUPPLEMENTARY INFORMATION:

#### Table of Acronyms

DHS Department of Homeland Security  
FR Federal Register  
NPRM Notice of Proposed Rulemaking  
TFR Temporary Final Rule

#### A. Regulatory History and Information

On April 6, 2007, the Coast Guard published an NPRM for the events that are listed within this regulation and made them available for public comment (72 FR 17062). No comments were received. The Coast Guard followed this NPRM with an Final Rule on September 27, 2007 (72 FR 54832).

On June 14, 2013, in an effort to provide the public with the most accurate and up-to-date information regarding these same events, the Coast Guard published an NPRM entitled Regattas and Marine Parades in the COTP Lake Michigan Zone in the **Federal Register** (78 FR 35783). We did not receive any comments in response to the proposed rule. No public meeting was requested and none was held.

#### B. Basis and Purpose

This rule is intended to ensure safety of life and property on the navigable

waters immediately prior to, during, and immediately after regattas or marine parades. This rule will establish restrictions upon, and control the movement of, vessels in a specified area of the Captain of the Port Lake Michigan zone.

For each of these events, the Captain of the Port, Lake Michigan, has determined that the likely combination of a race involving a large number of competitors, spectators, and transiting water craft in a congested area of water presents significant safety risks. These risks include collisions among competitor and spectator vessels, injury to swimmers from transiting water craft, capsizing, and drowning.

The authority for this regulation is 33 U.S.C. 1233.

#### C. Discussion of Comments, Changes, and the Final Rule

The Coast Guard received no comments on this rule. No changes have been made.

This rule will remove 1 event and amend 5 annual marine events listed in 33 CFR Part 100. This rule will amend 33 CFR Part 100 by making updates within the following sections:

33 CFR 100.903, Harborfest Dragon Boat Race; South Haven, MI. The Harborfest Dragon Boat Race is an annual event involving an estimated 250 participants maneuvering self-propelled vessels within a portion of the Black River in South Haven, MI. The organizer for this event submitted a 2013 application showing a date that is different from what is currently codified within the CFR. For that reason the Coast Guard will amend 33 CFR 100.903 to reflect an updated effective date for this event of Saturday and Sunday of the 4th weekend of June, from 6 a.m. until 7 p.m.

33 CFR 100.904; Celebrate Americafest; Green Bay, WI. This event will be removed by this rule because it has been codified within 33 CFR 165.929 Safety Zones; Annual events requiring safety zones in the Captain of the Port Lake Michigan zone. The Coast Guard determined from past experience that a safety zone best addresses the safety hazards associated with this event.

33 CFR 100.905; Door County Triathlon; Door County, WI. The swim portion of the Door County Triathlon is expected to involve thousands of participants in the waters of Horseshoe Bay—a portion of Green Bay. As this event is currently listed, the effective date expired on July 23 and 24, 2011. The Coast Guard has spoken with the event organizer and confirmed that this Triathlon is expected to reoccur